Employee Input and Health Care Cost-containment Strategies

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Executive Summary

Health insurance premiums have risen steadily in recent years and many employers are coping by increasing employee contributions to the premium. There exists the real danger that a substantial number of employees will refuse offered insurance because of the escalating contribution required of them. This likelihood caused us to ask whether there was a way, or ways, to structure cost increases that would minimize insurance dropout. We wanted to determine how employees thought cost increases should be absorbed, and what aspects of their insurance they would be willing to give up if their policies had to be substantially slimmed down. We sought to elicit the employee's voice, not only to ascertain an opinion on this question, but also as a first step toward increasing employee ownership of and responsibility for our employer-based health insurance system.

In our research, employees expressed a variety of preferences regarding how health insurance should be structured, in order to remain affordable to both employers and employees. Employee preferences are a function of several factors including income, education, current contribution to premium, and health status; therefore it was not surprising that across a diverse workforce, employees have different preferences about what health insurance should look like under enforced cost-cutting (see Table 1). We found that currently, few employees outside of union situations are invited to strategize with their employer about how to best structure health insurance benefits to keep them affordable. Omission of employees from such discussions makes two things less likely: 1) that the average employee will buy into the employer's underlying goal of encouraging more responsible use of the health care system, and 2) that the employer will adopt cost-containment strategies that meet the varying needs and values of his workforce.

As an enhancement to the biennial Health Insurance Status of Massachusetts Residents (HISMR) Survey administered by the Massachusetts Division of Health Care Finance and Policy (DHCFP), respondents with employer-based health insurance coverage were asked to categorize each of six cost-saving strategies as either

acceptable or not acceptable. Respondents were then asked to name their first choice option among those presented. Subsequent to administering the HISMR survey, 30 in-depth phone interviews were conducted to learn about respondents preferences, as well as how benefits decisions were made at their workplace.

Of the six strategies presented, the one most often deemed acceptable was "limiting the respondent's hospital network to just two teaching hospitals but including all community hospitals"* (see Figure 1). Restricted networks, a characteristic of early, tightly managed HMOs in Massachusetts, had been phased out in the late 1990s due to significant employee, and then employer, pressure. The opening of managed care networks is blamed for at least some of the subsequent increase in premium costs, since it made care management more difficult and caused hospitals to withdraw price discounts that were promised based on expectation of specific HMO volume.

When respondents were asked to name their *first* choice among the six scenarios, half opted either for an increase in monthly premium or for an increase in copayment for physician office visits. These respondents, generally those with higher incomes and education, and lower current expenses for health care, represent the portion of employees with an ability and willingness to use their greater disposable income to retain freedom-of-choice of providers in their health insurance (see Figure 2). They can absorb higher premium contributions and copayments, and while imposing such increases would not cause them to change their care-seeking behavior, it would at least mean that they were paying more for the freedom they value.

* There are 18 teaching hospitals in Massachusetts and residents use them far more frequently than average for the United States as a whole. In general, care is more expensive at a teaching hospital than at a community hospital, even for comparable conditions.

Only 15% would choose, as a first choice, to restrict their hospital choice, but those who did had lower income and education, higher current contribution to health insurance premiums, and higher incidence of having a family member who had been uninsured sometime in the last three years. While an abundance of teaching hospitals is unique to Massachusetts (eastern Massachusetts specifically), this finding might signal a willingness of some employees to reconsider narrower networks and tighter care management if the alternative is unaffordable insurance.

The follow-up interviews revealed a great deal of sophistication about the use of health insurance and the current problems facing the health care system. While the largest number of respondents preferred to pay more in copayments and other out-of-pocket costs (if forced to give something up), our 30-person sample had a higher median income ($80,000 vs $75,000) than those who answered the biennial survey. Six of the 30 were not required to contribute any amount toward their insurance premium and each of three other respondents described their contribution to premium as low, cheap, or reasonable. But a significant number of others would prefer to reduce their benefit level (dental, mental health/substance abuse, eye care, alternative therapies, health club subsidy, and maternity were all mentioned) or narrow their network, rather than incur higher fixed costs.

These findings suggest that a single cost-containment strategy, employer- or insurer-devised in a vacuum, will not be effective in engaging employees in cost-containment efforts. A significant portion of the better-paid employed population can, and is willing to, contribute higher amounts toward their health care in order to retain their insurance as is. Others, however, some of whom state that they are already contributing the maximum amount feasible, would prefer limits on where they obtain their care, or other limits on their benefits, in order to keep costs down. There appears to be no one strategy that will accomplish the goal of motivating employees to use care more responsibly, without causing some to either forgo needed treatment or turn down insurance entirely, due to cost.

Introduction

Increasing employees' contribution to health insurance premiums reduces insurance coverage because fewer employees "take up" offered insurance.[i] In 2001, the Massachusetts Division of Health Care Finance and Policy (DHCFP) conducted a survey of Massachusetts employers which indicated that, in the prior year, 77% of employees who were offered health insurance by their employers took it up. However, Massachusetts employers reported a large increase in premium costs between 2000 and 2001 (19% for individual health insurance policies and 15% for family policies[ii]), and 2002 data reveal a blended 14.7% rise in premium cost nationally.[iii]

While the DHCFP survey showed that the average employer contribution for individual health insurance policy premiums remained constant at 81% from the 1999 plan year through the 2000 plan year, the employer contribution for family policies decreased from 75% to 73%. This 2% retrenchment in employer contribution seems modest, but compounded by the overall 15% price rise, it resulted in a 24% increase in annual costs for employees taking family coverage from $1,670 to $2,074. Over time, these increases are likely to result in a higher rate of uninsurance.

Knowing that employers have a variety of options about how to address cost increases, we wanted to elicit employee opinion about which options they would prefer that their employers adopt. We hypothesized that multiple strategies were necessary to contain costs without adversely affecting take-up. For example, perhaps some employees would prefer to promote overall cost-containment by accepting lower-cost health insurance options a more restricted provider panel, a reduced range of benefits, or increased copayments rather than absorb the cost of their usual plan through premium contribution increases.

Many employers have reacted to multi-year premium increases by exploring or adopting consumer driven health care. This is an umbrella phrase used to refer to a variety of health insurance scenarios, all of which have the goal of tightening the

relationship between employees and the economic consequences of their health care choices.[iv] Employers and policy makers have concluded that because of moral hazard the tendency of people to spend other people's money less carefully than their own insured people will not alter their use of the health care system until they are somewhat at risk financially for the care they seek. However, this movement currently seems to be about employees sharing more of the cost of insurance and care, but not sharing in decision-making about how to best use the dollars available.[v] Having input into shaping their employer's health policies seems fundamental to making the system truly more "consumer-driven." In addition, employers are less likely to succeed in changing employee behavior if they don t know what tradeoffs employees would find most acceptable in their health insurance benefit.

DHCFP initiated a research project to address this question. Agency staff solicited employee preferences about health care cost-containment in two ways:

- During the biennial Health Insurance Survey of Massachusetts Residents (HISMR) survey, a module was added for those who stated they had employer-sponsored insurance. The module presented six cost-cutting scenarios. Respondents first identified each scenario as either acceptable or not acceptable and then stated their first choice among the six.
- Thirty in-depth follow-up phone interviews were conducted with those who participated in the module.

This research provides useful information to employers and will hopefully stimulate a public dialogue about acceptable tradeoffs to escalating health insurance costs.

Methods

In 1998, 2000, and 2002, DHCFP conducted surveys to identify characteristics of the insured, uninsured, and underinsured populations in Massachusetts. The survey methodology is discussed in Appendix A. In 2002, everyone who reported that they had health insurance through an employer (n=1520) was asked to respond to the following questions:

> Recently we have been hearing a lot about rising health care costs. Most, if not all, employers offering health insurance are facing large premium cost increases, which may be difficult for them to afford. Your employer may consider adopting one or some combination of the following options in order to share some health care cost increases with you. For each of the following options your employer might consider, please tell me if the option would be acceptable or not acceptable to you:
>
> 1. No change to your health insurance benefits, but your monthly premium increases by $50/$25 (family/individual (f/i) health insurance policy).
> 2. No change to your health insurance benefits, but your copayment for doctor visits increases by $20.
> 3. No change to your health insurance benefits, but your copayment for prescription drugs increases by $20 for each drug.
> 4. No changes in benefits or costs to you, but you would need to accept a choice of physicians and hospitals that included all community hospitals, but only two teaching hospitals in the state. (*Note: This option is considered quite restrictive in Massachusetts where a greater portion of health care takes place in teaching hospitals compared to other states. This is thought to be one of the local factors that drives up the cost of health insurance*.)
> 5. Visits to doctors would no longer be covered or paid for through your insurance, but your monthly payment decreases by $50/$25 (f/i).
> 6. Prescription drugs would no longer be covered or paid for through your insurance, but your monthly payment decreases by $40/$20 (f/i).

If you were forced to choose among these six options, which would be your first choice?

In order to further explore employee perceptions of their health insurance, DHCFP conducted interviews of 30 employed individuals who had responded to the biennial HISMR survey and agreed to participate in follow-up inquiries. Respondents were not prompted about various cost-saving techniques, but were instead asked open-ended questions about their ideas. See Appendix B for the interviewer script.

Findings/Results

Among the six cost-saving options presented, the most frequently named acceptable was limit of two teaching hospitals (42.6%). It was followed by increase in monthly premium (38.1%) and increase in copayment for office visits (25.0%) (see Figure 1). The options least frequently named acceptable were increase in copayment for prescription drugs (19.6%), no coverage for prescription drugs, coupled with premium reduction (15.2%), and no coverage for office visits, coupled with premium reduction (15.0%).

When respondents were asked to pick their first choice among the six options, half opted for an increase in monthly premiums (31.2%) or copayment for office visits (20.2%). These two preferences were also most frequently volunteered by the respondents in the follow-up interviews, often explicitly linked to keeping freedom-of-choice. Among those who already felt they were paying the maximum amount they could afford for premiums, there was widespread feeling that copayment increases were easier to absorb than premium increases. Fewer respondents opted for the following first choices: limit of two teaching hospitals (15.6%), no coverage for prescription drugs, coupled with premium reduction (9.6%), increase in copayment for prescription drugs (7.7%), no coverage for office visits, coupled with premium reduction (5.1%). Almost 11% stated "none of the above" as a first choice among the six.

In the follow-up interviews, only four respondents could not offer a suggestion about how their employers could save money. Several respondents volunteered that they didn't want their drug plan to be changed, pared down, or eliminated. Benefits that were suggested for elimination tended to be those that respondents had never used or no longer use, which would raise adverse selection issues if implemented[vi] older people mentioned maternity; others mentioned mental health/substance abuse treatment, alternative therapies, health club subsidies, and dental care.

What Influences Preferences?

Premium increase as a first choice among the six options (31.2%) increased as income, education, and rating of current premium amount (too much, a little too much, about right) increased (see Figure 2). Conversely, this choice decreased as office visit copayment amounts increased. This was a more likely first choice for males ages 40 and above with excellent to good health status, $200 or more out-of-pocket expenses, and no family member uninsured anytime in the last three years (see Table 1). The follow-up conversations revealed great differences in employer policies for covering health insurance costs. Some employees can and are willing to contribute more (sometimes significantly more) toward their health insurance (especially to retain the status quo) than they do, because they contribute little or nothing now. In fact, the 2001 employer survey conducted by DHCFP indicated that 40% of small employers (those with fewer than 50 employees) in Massachusetts who offered health insurance paid 100% of the premium.

Office visit copayment increase was the first choice (20.2%) of those with incomes over 200% federal poverty level (FPL), a high school but not college degree, poor health status, and who rated their premium contribution as about right or a little too much. This was also the first choice option of those with office visit copayments up to $25, out-of-pocket expenses rated as somewhat or very difficult to afford, and no family member uninsured in last three years. This option gradually decreased among respondents whose premium from last year moved from less to same to more. In follow-up interviews, several respondents who felt they already paid a lot in premium were still willing to increase office visit copayments or pay a deductible in order to retain freedom-of-choice and all benefits.

Preferences of Lower-income/Less-educated Respondents

As income, education, age, and family size decreased, and office visit copayment increased, more respondents (15.6%) selected limit of two teaching hospitals as their first choice option. This option was more popular with women, policyholders with family plans, and households with a family member uninsured during the last three years. This option was also chosen more often with an increase in premium from last year ("less" to "same" to "more"). Answers about limiting a network were equated to accepting a "limit of two teaching hospitals." This was relatively unpopular even though only a few respondents mentioned that they had ever utilized freedom-of-choice to handpick clinicians in diverse settings. Rather, people seemed to want to know I can go anywhere, choose any doctor I prefer, have complete freedom-of-choice, and never accept a limit in choice of doctors, even in the absence of both serious illness and objective data about physician performance. Choice of physician/hospital seems to be a psychological need that many consumers are willing to pay for, in order to have peace of mind, just in case. The exceptions to this finding were people who were very young and healthy,[vii] or already at the limit of what they could spend for health insurance.

About 11% of respondents stated "none of the above" when asked to name a first choice; this was more likely with lower education and income. In addition, those who rated their premium amount as much too much or their out-of-pocket expenses as very difficult to afford more often found no option preferable. In the follow-up interviews, a few respondents said that they could neither afford more cost, nor forgo any current benefit. One respondent stated that he was unwilling to give up anything because you never know what will happen.

Correlation between Insurance Preference and Other Factors

Insurance payment preferences vary with several factors (see Table 1). Two demographic variables (income and education) and two insurance variables (copayment amount and family member uninsured in last three years) were correlated with naming, as a first choice, one of the four most popular options. Premium increase and office visit increase as first choices increased with higher income and education, and lower office visit copayment, and were more often chosen when no family member had been uninsured in the last three years. In contrast, choosing limit of two teaching hospitals and no option acceptable increased as income and education decreased, and office visit copayment increased; it was more often chosen when a family member had been uninsured in the last three years.

Conclusion

Employees showed strong variability in how they preferred their employer to keep their health care coverage benefit affordable. Those in the lowest income group preferred a limit on where they obtained care to a premium or copayment increase. It is reasonable that lower-income individuals would prefer to accept restrictions on their access, rather than jeopardize their insurance altogether. In contrast, those with more disposable income preferred to pay for choice rather than accept any restriction in provider. Those who reported fair or poor health status expressed preferences (physician copayment increase and limit to two teaching hospitals) that would affect them particularly (assuming they obtain more care than those in excellent, very good, or good health), but would avoid fixed premium increases.

The results of this research study clearly support the conclusion that one size doesn t fit all. A standardized employer-sponsored health insurance program, that treats each employee identically, offers administrative simplicity that is highly valued by employers. However, this approach ignores the reality of vastly different household incomes, very different health care needs, and a wide spectrum of values, all of which were evident in our interviews. While a $25 copayment for a physician office visit might not cause a middle class family to forgo a necessary visit, it might well cause a poorer family not to seek needed care.[viii] Moreover, a $25 surcharge on teaching hospital care is unlikely to motivate a higher income family to switch care to a community hospital from a more expensive teaching hospital.

Policymakers view premium sharing as useful for cost-sharing only, having no long-term impact on health care-seeking behavior. So, while employers would obtain short-term relief by contributing less to employees health insurance, other strategies might convince employees to examine and perhaps change their behavior. Employers seeking to raise employee awareness and sensitivity might start by doing what one respondent reported his employer sends each employee a year-end summary of all

health care services their family used that year, and the actual price the employer paid for those services.

Greater premium sharing alone does not have the effect of steering the patient toward more efficient treatment or less treatment if all providers are covered equally. Indeed, having paid more for the insurance, one might be more inclined to make use of it to get one s money's worth. Eventually, greater premium-sharing will result in some employees turning down offered insurance; but that threshold varies across income levels. To avoid turn down (and we believe that most employers do not want to encourage that response), employers must recognize the variability in income and values across their work force.

Employees are currently a largely untapped resource for employers trying to determine the best approach to manage health care costs. Union negotiators readily see the intimate relationship between an employer s contribution to premium and money available for wages. A Hewitt Associates report quoted in *USA Today* (J. Appleby) on November 4, 2002, stated that health insurance premiums, which are increasing at their fastest clip in a decade, will eat up workers pay raises next year. Workers health costs will increase by an average of $342 to $1,753 next year. For a worker who earns $597 per week the national median and receives a 4% raise, rising health care costs would constitute 28% of the pay increase. If employers tap employee opinion, continue to educate them as to the nature of the problem, and enlist their help in taming health care costs for their common benefit, surely both parties, as well as the health care system, would benefit.

While this study illustrates the variability in employee financial capacity and values regarding health insurance, more work remains to be done. These questions were posed in a hypothetical situation. The next step is to introduce into several workplaces an employee-centered process in which employees contribute to strategy development; multiple incentives are put into place to curb expenses; and a robust measurement system tracks resulting costs, health status, satisfaction, access, and insurance turndown.

Appendix A: Survey Methodology Health Insurance Status of Massachusetts Residents (HISMR)

Along with the 1998 and 2000 HISMR surveys, the 2002 version was developed through a collaborative effort between the DHCFP and the Center for Survey Research at the University of Massachusetts-Boston.

The survey consisted of random digit dial (RDD) telephone interviews, where the sample is drawn from telephone listings. Interviews were conducted using computer-assisted telephone interviewing (CATI) technology. The survey design is a simple stratified sample by five regional areas in the state. The questionnaire is available in both English and Spanish.

The 2000 and 2002 surveys included a survey of additional households in five urban areas in order to develop valid estimates and identify characteristics of the uninsured in these urban areas. The five urban areas are Boston, Springfield, Worcester, Lowell/Lawrence and New Bedford/Fall River.

The statewide 2002 survey was conducted from late February through September, 2002. Information was collected on 2,635 households and 7,040 individuals. The response rate was 60%**,** comparable to the previous two surveys. Of those who responded, 1520 individuals reported having employer-based health insurance coverage and were asked the additional questions referred to as the Commonwealth module (see page 9 under Methods for script). For most questions reported in this publication, 1391 (91.5%) responses were included for analysis, representing those individuals who offered a first choice among six cost-cutting scenarios, or who stated "none of the above". Respondents who stated "I don't know" in answer to the request to make a first choice among the six scenarios were omitted.

Cost-sharing preferences are a function of many factors. Therefore, first choice options were cross-tabulated with responses to survey questions on selected demographic and insurance characteristics to explore possible correlates. These characteristics were

age, gender, race, marital status, income, education, health status, number of family members in household, type of coverage, premium contribution, change in premium, current amount for office visit copayment, out-of-pocket amount and affordability, and uninsured family member in last three years.

Appendix B: Survey Methodology Qualitative Follow-up Interviews

In order to further explore consumer perceptions of their health care insurance, the DHCFP conducted 30 additional interviews of employed individuals who had previously responded to the HISMR survey and agreed to participate in follow up inquiries. The University of Massachusetts Center for Survey Research drew a purposive sample for this effort; individuals were selected according to the following general guidelines:

- Receive employer or union sponsored health care coverage
- Divided between individual and family coverage in roughly the same proportion as statewide (1/3 individual)
- A few union employees
- A range of ages
- A range of incomes
- A few respondents with fair or poor health status
- Geographic variability

Sixty-eight percent of HISMR survey respondents with employer-sponsored health insurance (but only 50% of those who reported household income <125% FPL) agreed to such a follow-up phone call. Respondents were interviewed over the telephone using a semi-structured protocol, with open-ended questions (below). Almost all respondents who were contacted agreed to be interviewed. The interview lasted about fifteen minutes; respondents were compensated $10 for participating. Four staff conducted interviews; each interviewer conducted at least six interviews. Interviews were conducted only in English, which appeared to be each respondent s primary language.

Interview Script:

> A couple of months ago, you received a phone call regarding a survey about your health insurance. At that time, you said you wouldn t mind it if you got another call in the future to ask a few more questions. The purpose of this call is to follow up on the survey and get a little more information from you about your preferences about

health insurance. The Commonwealth of Massachusetts would like to understand more about how you get and pay for health insurance. Your answers are completely confidential. We will send you $10 for participating.

1. How do you get health insurance? *If the respondent does not have employer-based or union insurance, then politely end the phone call.*
2. Are you the policyholder for this insurance?
3. Is this an individual or family policy?
4. What health insurance plan do you have? *name of plan*
5. Did you have a choice among health plans? *If not, skip to question nine.*
6. Did your employer (or spouse s employer) help you understand the different options that were available to you and which choice was best for you?
7. How did your employer help you understand? *literature; information sessions*
8. Why did you pick this plan? *price of plan to you, out-of-network provider option, out-of-pocket costs, range of benefits*
9. Do you think you have a good understanding about what benefits and services your health insurance covers?
10. If yes, how did you find out about these things?
11. How often do you or your family use health care services? What types of services do you typically use?
12. What do you like best about your health insurance coverage and benefits? *freedom-of-choice, range of benefits, simplicity of use, price*
13. Does your health insurance give you access to providers and benefits that you don t really use or you think you are not likely to use?
14. If your employer needed to save money on health insurance, what would you tell him/her you would be willing to give up?
15. What would you least like to give up to achieve cost savings?
16. Why would you make these choices?
17. Does your employer include employees in decision-making about what type of insurance and benefits to offer?

Please give us your name and address so we can send you your $10 gift.

Thank you for participating.

Appendix C: Aggregated Findings of Follow-up Interviews

The 30 respondents were fairly evenly divided by gender (14 males:16 females) and included ages 23 to 61. Average age was 42 years. Reported annual incomes ranged from $3,000 to $250,000, with an average of $75,815 (median=$80,000). Respondents reported a range of health status: six excellent, ten very good, six good, two fair, and six unknown. Three respondents received health care coverage through a union and the remainder directly through an employer. The respondents represented all geographic areas of Massachusetts as measured by area code, although there was an over-representation among respondents in the western part of the state (area code 413) and an under-representation of respondents in the Boston area (area code 617). There were respondents from each of the state s three major cities: Boston, Worcester, and Springfield.

About 40% (12) of respondents had individual health insurance coverage. About 77% of respondents had a choice between either two to three health plans. Most of the health plans selected were managed care products.

Respondents were asked why they selected their health plan. Twenty-three percent said they had no choice of health plan. Twelve (40%) said they selected the plan because it gave them a choice of provider or had a broad provider network. Eight (27%) selected the plan due to price. Three respondents gave other reasons.

Respondents found out about their health benefits through written literature provided by the employer, orientation or informational sessions sponsored by the employer, or contacts with the health plan. Most respondents thought they had a very good, good, or good enough understanding of their health care benefits, while three felt they were not well informed at all, and six did not respond to the question.

The aspects of their health plan that respondents liked best were freedom-of-choice and the network of providers (13), two respondents liked the price best, three liked

the convenience of the plan or ease of use, two gave multiple aspects of the plan that they liked best including combinations of the reasons already mentioned. Seven respondents did not identify an aspect of the plan they liked best.

Seven respondents said there were benefits offered by the plan that they were unlikely to use; these included mental substance/substance abuse, dental, maternity, or fringe benefits, such as health club enrollment.

Respondents were asked if there were aspects of their health plan they would be willing to give up if their employer or union had to save some money. The most frequently cited response was that respondents would be willing to pay more in copayments (nine) or other out of pocket costs (eight). Six people (ages 24-61) offered the information that they paid nothing for their health care coverage; and others said they paid a very low amount. Six respondents said they would be willing to give up benefits, two specified prescription drug coverage, one said nothing, and four were not able to identify anything they would be willing to give up.

Respondents were also asked what they would least like to give up if the employer needed to cut back. Ten respondents could not identify something they would least like to give up. Six said they would not want to give up freedom-of-choice of provider, four said they would not want higher copayments and one said he/she would not like to pay more for other out-of-pocket costs. Four do not want to have to pay more for prescriptions, three do not want to give up benefits, and two do not want to give up anything.

Only five respondents said that employees at their work site were included in decision-making about health plans to offer. Three of these respondents were in unions, one said employees were included in a decision-making committee, and one said the employer solicited employee input into health plan decisions. One person in a unionized workplace volunteered that he got a printout each year that listed his specific health care service usage and its actual cost for the prior year.

These results suggest that employees choose their health plan based on freedom-of-choice of provider and price. Respondents are willing to pay a bit more for their health care coverage, but there is not as much consistency about what employees are least likely to want to give up. Employees are typically not included in decision-making about health care plans.

These quantitative data provide a descriptive summary of how respondents answered the specific questions we asked in our telephone interviews. However, we used an open-ended format to allow interviewees to expand on their responses and offer insights into reasons why they answered as they did. These responses are not easily quantified, but do offer rich descriptive data about employee health care coverage decision-making.

In general, we found respondents to be sophisticated in their understanding of their health care benefits and in their rationale for selecting the plan that they did. Examples provided by individual respondents demonstrate this reasoning:

- A 29-year-old man in very good health selected a plan that did not have an eye glass benefit, so that he could use those points to select another optional benefit of more importance to him.
- A 61-year-old woman has retained her health plan because it allows for continuity of coverage for her adult child who has a disability.
- A 40-year-old male with a foot problem uses his regular coverage for routine care and his VA coverage for specialty podiatry care.
- A 46-year-old woman with Lyme disease selected her health plan because it gives her access to a health club, so she can continue to exercise under controlled conditions
- A 27-year-old male selected a PPO, rather than an HMO, so that he could continue to see a specialist for a kidney disorder
- A 32-year-old male in great health said his priorities in selecting coverage were to ensure he had ample coverage for catastrophic care and reasonable copayments for basic services

- A 58-year-old woman chose her plan because it had copayments instead of less predictable co-insurance.

These examples show that many employees were clear and specific in the reasons they selected their health plan. These decision reflect a desire to obtain the health care coverage that offers the best value to the employee, although the meaning of this value varies from respondent to respondent, depending on the individual s life circumstances. In one case it will be freedom to access a specialist, while in another it will be the opportunity to join a health club subsidized by an employer. The variability among respondents in the choices they made and their explanations for these choices offers new insight into health care coverage decision-making. Moreover, in more than half the cases, the benefits offered by the selected health plan were so valuable to the employee that the employee indicated a willingness to pay more out-of-pocket to retain that benefit. The sophistication of employees in health care coverage decision-making suggests that they are a potential resource to employers as they struggle to make decisions about how to maintain adequate health care benefits even as costs continue to climb.

Appendix D: Individual Interview Reports

Respondent: 23-year-old woman

- Individual coverage; Fallon Health Plan.
- Her employer offered her a choice but she doesn't remember the other choices or why she took Fallon. Fallon is convenient and accepted everywhere in her area.
- She doesn t use health care services very often.
- If she had to pay more for health care, she would rather it be for prescription drugs. She implied that she doesn't use any prescriptions on a regular basis.
- She works for a small employer, but has not been there long. She pays toward the health insurance premium, but didn't remember the amount.
- She doesn't know if employees are consulted about health insurance decisions, but she hasn't seen any evidence of that during her tenure.
- She lives within the city of Worcester.

Respondent: 23-year-old man

- Individual coverage; HMO Blue.
- Interviewee is a new employee at a medium-sized company, which offered two or three plan options.
- While he didn t think too hard about his choice of plans, he opted for the basic HMO because he considers himself in good health and doesn t need more than a good PCP.
- His priorities in choosing a plan include reasonable copayments and access to physicians he likes.
- He likes the hospital and physician network offered under his current plan, and mentioned the importance of quality member services.
- He considers himself someone who doesn t go to the doctor more than is recommended for someone in good health once or twice a year.
- His guess is that he contributes 50% to the monthly premium.
- Benefits like mental health, eye care, and gym memberships are his lowest priority he would be willing to sacrifice them if the company were cutting back.
- He is unwilling to pay more, particularly in copayments, at this point in his life.
- He has been pleasantly surprised by the company s orientation for new employees regarding health care benefits.
- He does not know the frequency with which his employer updates employees, but he found the informational meetings, literature, updates, and support services in the HR department to be very good.
- He does not believe that the company directly designs its health plans based on employee preference, but he suspects takes into consideration the demographics of its employees.

Respondent: 24-year-old man

- Family coverage; Tri-Care.
- This man serves in the Coast Guard and is stationed at Otis Air Force Base, Cape Cod. As a member of the Armed Forces, he is automatically enrolled in Tri-Care, the Department of Defense insurance program. Through this plan he can get free health care at the clinic on the Air Force Base, or he can go to any hospital where services are also completely covered.
- His wife is covered under his policy, although she pays a copayment if she uses services off the base. The couple has no children.
- He learned about the benefits of Tri-Care through classes at boot camp. He feels he has a pretty good understanding of the benefits.
- He has been in the Coast Guard for two years. During that time he has used health services five to ten times; his wife has used them only twice. They have used dental services; he has had a couple of trips to an emergency room and they have had regular check-ups.
- The best aspect of the Tri-Care plan is the price. He does not believe that there are benefits that they are not likely to use.
- If necessary he would prefer to pay more for the premium, and he is least likely to give up freedom-of-choice. He likes to know that I could go anywhere.
- Since the Department of Defense sponsors the plan, he is not aware of employee involvement in decision-making about health plans.

Respondent: 26-year-old woman

- § Family coverage; Tufts PPO.
- § Interviewee was a BCBS HMO individual policyholder at the time of the HISMR interview, but since then has moved on to her husband s plan.
- § Reasons for this move were twofold:
  - – Larger network of physicians. Specifically, her husband s PPO includes a specific chiropractor that was not included in her company s physician network
  - – Her employer offers $500 cash annually for employees who do not use the company s health insurance; this motivated her to switch to her spouse s plan.
- § She has a choice between different types of plans at both her company and her husband s, but primarily it is the difference between a PPO and HMO.
- § She believes that the Tufts PPO is affordable, has a wide network of physicians, and a better range of benefits.
- § She believes that she has a good understanding of the benefits and services Tufts offers, but it is due to her proactive inquiry.
- § She and her husband use health services at a moderate level (PCP, Ob/Gyn, etc.). She anticipates using a chiropractor regularly.
- § What she likes best about her new health insurance coverage is the combination of low cost, breadth of benefits (gym, chiropractor, acupuncture, etc) and the scope of network providers.
  - – Member service is important, but not as important as cost or access to providers.
  - – She would be willing to pay higher copayments especially for specialty services.
  - – While they probably could pay a higher premium comfortably with their salaries, she prefers the ability to decide on a case by case basis whether she wants to utilize specialists and benefits outside the basic ones provided, factoring in whether she is willing to pay the extra copayment. Thus, if they end up under-utilizing services, they aren t penalized by a high premium.
- § Neither her employer nor her husband s involves employees in decision-making regarding what types of insurance or benefits to offer. She would be interested in participating in those types of decisions.

Respondent: 27-year-old man

- Individual coverage; BCBS.
- This man said he has an HMO (but it sounds like a PPO). Visits to his PCP are covered 100% with a copayment. He is also allowed to go out-of-network, covered at 80%.
- His employer provided three insurance options and he chose the one that would give him greatest freedom-of-choice.
- The employer provided a booklet about each plan, and that was all the information he received. He has an average understanding of the benefits and services, as a result of reading the material.
- He uses health care services twice a month. He sees an internal medicine doctor regularly for his kidney problem. He also sees a specialist once in a while for his kidney. For these visits, he self-refers and pays the higher rate.
- The best part of his plan is the freedom-of-choice. There are not extra benefits that he is unlikely to use.
- He would elect to give up dental coverage if he had to. He does not want to give up the freedom-of-choice.
- There is no employee involvement in the health plan decision-making of the employer.

Respondent: 28-year-old man

- Family coverage; Aetna Health Plan.
- He did not have a choice among health plans.
- The plan covers the employee for free. His wife pays a premium to be covered under the plan. She is self-employed. She previously paid for her own individual health insurance coverage, but within the last year switched to his plan.
- The employer gave employees a pamphlet that describes the benefit package. However, he did not feel that he has a good understanding of his benefits.
- The respondent uses health services once or twice each year. His wife uses services more frequently, at least once per month. She uses prescription drugs and also has checkups and visits to her gynecologist.
- They are restricted to providers in a network. However, the network includes nearly all providers in the area, which is central Massachusetts.
- There is nothing that he would change about his health plan.
- The plan offers more benefits than he needs, but he likes having the coverage in case he needs the services in the future.
- If necessary, he would prefer to give up some of the benefits or freedom-of-choice of provider.
- He is least likely to give up prescription drugs.
- A committee of about six employees negotiates the health plan. The company employs about 200 people. As a result, he feels that employees have a say in health care coverage decision-making.

Respondent: 29-year-old man

- Individual coverage; CIGNA Health Plan.
- This man had a choice of several CIGNA plans. His employer gave employees an allocation of points to use on various benefits. The health plans offered cost various amounts of points. He couldn t remember if the various plans also cost different amounts of money.
- He lives within the city of Springfield.
- He learned about the different plans from literature. He has had his plan for a while. He picked this level of plan because it had the coverage he needed. It is a mid-level plan. The plans mainly differ in freedom offered. All have pretty similar copayments for office visits and pharmaceuticals.
- He has a good understanding of its benefits. He is in a management position, but in a unionized company. He is given a book each year outlining what has changed.
- He sees a doctor each month for allergies. He takes medicine regularly for allergies.
- He likes that the plan is well managed. Each year he gets a printout of all his medical use, showing how many visits he had, how many prescriptions etc and what the company paid for them.
- He likes the plan's flexibility. He has excellent vision, so he picked a plan without an eyeglass benefit, which saved him points for something else.
- If he had to, he'd pay more in premiums than he does. He said he pays $7/week now. He wouldn't give up prescription coverage.
- His company s benefits are set centrally. To his knowledge, no employees outside of Human Resources are involved in these decisions.

Respondent: 30-year-old woman

- Family coverage; Tufts HMO.
- Her employer gave her a choice of several health plans. She had not heard of the other plans and so decided to enroll in Tufts. In addition, it was almost the cheapest of the plans that were offered.
- Her employer had an orientation session to educate employees about the health plans that were available. There was literature available and representatives of the plans.
- She understands the benefits somewhat. Due to an illness, she has had to do additional research to find out what benefits were covered.
- She uses the health plan quite often at least once a month. Her kids use it for routine check-ups and typical sick childcare.
- She likes that the plan is easy to use.
- There are benefits that she believes she will never use, such as services for drug or alcohol dependency.
- If her employer needed to save money on health insurance costs, she would be most likely to give up the drug and alcohol treatment benefits.
- She would least like to give up her choice of physician. She has regular physicians that she uses all the time and she would not like to give them up.
- She also mentioned that she is not happy about recent health care price increases.
- Employees are not involved in health insurance decision-making at her company.

Respondent: 32 year-old man

- Individual coverage; HMO Blue.
- Works for a law firm with fewer than 50 employees.
- He hasn t kept himself well informed of benefits.
- His firm offered two or three different plan options; he looked for the most basic.
- Because he considers himself young and in great health, a person who rarely utilizes services, he looked for a plan that would cover catastrophic care.
- Currently, he is not completely satisfied with BCBS. Dental and eye coverage is weaker than in his previous plan. He is paying all expenses for contact lens for the first time.
- He believes non-traditional services like acupuncture, nutrition consultations, gym memberships etc. benefit a population s health in the long-term, so theoretically he is in support of them. However, these benefits are his lowest priority, and they would be the first thing he d sacrifice if his employer had to scale back.
- His priorities include ample coverage in the event of catastrophic care, and then reasonable copayments for basic services.
- He does not recall how much he contributes to the monthly premium compared to his employer, but he considers the dollar amount he pays reasonable.
- His law firm does not get any more involved than by providing a handbook explaining coverage options, physician networks and benefits.

Respondent: 33-year-old woman

- Family coverage; BCBS PPO.
- They had a choice of three or four health plans and chose the PPO because it offered both in and out-of-network doctors and made the most sense financially.
- They received written information about their benefits from the employer. There was a booklet that described each of the plans. They have a good understanding of their benefits, which they gained from reading the written material.
- They use health services about once a month. They have a nine-month-old child. They use physician services and prescription drugs.
- She likes best the number of physicians in the network, and the low out-of-pocket costs.
- She cannot say whether there are benefits offered through the plan that they are not likely to use.
- If she had to give up something, she would be willing to pay more for copayments but not more for premiums. The premiums are high already.
- She does not know whether employees are involved in health care decision-making at the company.

Respondent: 34-year-old man

- Family coverage; BCBS PPO.
- Employer currently offers three plans.
- Interviewee named the quality of pediatric care as the deciding factor for which plan to choose. He wanted a specific pediatric practice that was available under the PPO and routine pediatric care until the child is 19 or 20.
- Other reasons for choosing the PPO included: more control over type of care, larger network; choice of doctor and hospital.
- His family are moderate users of services.
- He believes he and his wife are aware of the terms of insurance and benefits offered.
- He would be willing to pay higher copayments for specialty care and drugs.
- He would be less willing to give up access, size of network, and quality of care.
- He and his wife want consistent care for their children, namely using the same physicians over a long period of time.
- His employer does not include employee input when deciding what type of coverage or benefits to offer.
- The employer offers a basic, annual, informational meeting; literature; and publicizes the health plans websites.
- He is satisfied with the performance of his health care and coverage.

Respondent: 36-year-old woman

- Family coverage; HMO Blue.
- Health insurance provided by husband s small employer.
- Employee had to choose between an HMO and a POS.
- Optional informational meetings and literature provided to employees; unsure if husband attended meetings.
- Interviewee does not know price of premium or copayments, range of benefits, etc.
- Prefers HMO to POS because of lower cost and ease of understanding.
- Believes she has basic understanding of benefits and services from literature provided by health plan.
- They use minimum services because the family is very healthy and primarily uses the family doctor (PCP).
- In her opinion, important features of a plan include low premium and copayments, easy access to doctors, and wide range of benefits
- If employer had to save money on health insurance, interviewee had no strong opinion on what she would be willing to give up probably the number of benefits.
- Employer does not include employees in decision-making about type of insurance or benefits.

Respondent: 40-year-old woman

- Family coverage; BCBS.
- Recently retired.
- She was unable to distinguish whether it was an HMO or PPO in this conversation (it sounded like an PPO).
- Her employer provided two or three plan options.
- Her employer was thorough in educating its employees through informational meetings and literature, and by providing a point of contact.
- As a retiree, she receives mailings almost weekly about her health insurance and/or how to stay healthy. They come from both the company and BCBS.
- She did not know the exact premium she or the company paid, but felt her premium was high for a monthly fee..
- In deciding what plan to go with she wanted a particular hospital in the network and wanted to avoid needing a referral. She also wanted to be able to choose any doctor.
- She is satisfied with her current plan, although it is expensive.
- She considers her family healthy; her own health is okay.
- They visit a doctor or hospital no more than once a month, if that.
- She does not take advantage of services such as acupuncture or gym memberships, etc. She considers herself a traditional user, visiting her PCP and gynecologist mainly for regular, annual visits.
- If her employer needed to save money on health insurance, she would opt to pay a little more for her copayments. Her second choice would be to limit some of her benefits. Next, she would limit her provider network.
- She would not be willing to pay much more on top of what she considers an already high premium.
- Lastly, she said her employer made an effort to solicit the opinion of employees, and that is one reason why, she believes, the company offers so many different types of plans.

Respondent: 40-year-old man

- Family coverage; BCBS PPO (Blue Choice).
- This man receives health care coverage through his union.
- The employer pays 80% of the premium.
- He had a choice among health plans and chose this policy because he did not want an HMO, wanting to make sure he had adequate benefits.
- The employer provided pamphlets about the different policies that were available. He said that the pamphlets provided a pretty good understanding of his choices.
- He said he uses health care not too often, and not unless I have to.
- He also receives VA benefits. He is 20% disabled due to a foot problem. He sees a podiatrist at the VA who follows him for the foot problem.
- He likes Blue Choice due to the price, simplicity of use and the wide range of benefits.
- There are not benefits that he thinks he will not use since you never know what will happen.
- There is nothing he would like to give up in his benefit package. The wide choice of benefits give peace of mind.
- He would not want to give up any benefits because he is not paying for them. Once he worked for an employer that returned cash to the employee if the employee did not use benefits. If that were the case for his current employer, he might answer differently.
- Employees are included in negotiations around health care benefits as part of negotiating a union contract.

Respondent: 41-year-old man

- Individual coverage; Health New England..
- This man lives within the city of Springfield.
- He has had this insurance for several years. He chose this option (among several) because he works in Connecticut but lives in Massachusetts. The other plans offered are primarily Connecticut plans without a good choice of Massachusetts doctors.
- Every year his employer hosts representatives of all the health plans to explain their products.
- He pays $17.40/week. He is a member of the machinists union, so the amount is negotiated centrally by elected union representatives.
- He has a good understanding of the plan. He uses routine services twice a year, and gets three different prescriptions a month. He values the simplicity of the plan. He can't think of anything he isn't likely to need in the insurance.
- If pressed, he would pay more for prescriptions even though he uses three a month, but he is aware of paying far less than they cost.

Respondent: 44-year-old woman

- Family coverage; Tufts PPO,
- This woman lives in Springfield, works for the Commonwealth of Massachusetts, and reports an income of $21,000.
- Tufts PPO was the most affordable to her; she has had it for at least eight years.
- Her employer held meetings and offered literature about the various plans.
- She feels she has a good understanding of the health plan's benefits.
- She sees a doctor every four months for chronic asthma. Her husband goes once a year; her daughter, as needed.
- What she likes best about the plan is the freedom to choose her own doctor.
- It probably has benefits she isn't likely to need but she couldn t identify any.
- When asked about how she would suggest a cost increase be paid for, she said she had just had a large premium increase. Her premium went up 15% to $53/biweekly. Her pharmacy and office visit copayments have also risen. She couldn't identify any preference for absorbing additional increases, should they be necessary.

Respondent: 44-year-old male

- Individual coverage; Aetna Health Plan.
- Originally this was the only plan offered, but last year his company began offering a PPO. He did not opt for this new plan. He does not feel as though he had a good understanding of his plan.
- His employer did not educate him on his health plan.
- He has diabetes and has had to fight them to pay for a blood test for the past six months.
- He utilizes health services every quarter for a diabetes check up. He uses services mostly related to his diabetes.
- When asked about services he may not use he said there were none, even after probing.
- When asked what he would want to give up if times were tough he said it didn t really matter to him, but when I asked what he would least like to give up he said his premium is very cheap and he doesn t want that to be increased.
- He said the employees at his company have no say in terms of health insurance decision-making, it is all done in corporate.

Respondent: 45-year-old woman

- Family coverage; BCBS.
- This woman lives in Springfield and reports a family income of $90,000.
- She and her husband have owned their own business since 1989 and have used BCBS for health care since then.
- The business pays 100% of its employees' premiums because its two employees are other family members.
- This year their family plans increased $100/month in price and the one individual health insurance plan they buy rose $50/month.
- Her family is a frequent user of health care.
- She is satisfied with the health plan but feels the premiums are way too high. The premium and the copayments for prescription drugs and doctor visits rose significantly at last renewal.
- She considered changing to a lower priced plan, but she didn't think it would save them any money, given that those plans had higher copayments and deductibles, and her family uses care frequently.

Respondent: 45-year-old woman

- Family coverage; HMO Blue.
- Interviewee is a nurse at a hospital.
- Family recently switched plans, due to her husband s unemployment; she is now the policy holder.
- The hospital provided three choices including its own plan.
- The hospital organizes an annual benefits meeting and also posts updates on-line.
- The hospital incorporates questions about employees preferences and satisfaction with health plans in an annual satisfaction survey.
- The premium rate for both health and dental insurance is $400 per month; the hospital pays more than half.
- She said that the particular attributes she was looking for were easy access to physicians (without long delays for appointments) and few physician network restrictions. She knows specific physicians and practices she wants access to; she wants to be sure those physicians are available and will stay with the plan for a reasonable period of time; and in the past, with Tufts and Baystate plans, she was frustrated with physician network restrictions.
- She is satisfied with HMO Blue, but the change in plans resulted in a noticeably higher deductible and a higher premium.
- She is willing to pay a higher deductible for more choice.
- Her family is very healthy. However, she believes in preventive care. While they only need physician and dental visits one or two times per year, they are very conscientious about their health and she wants to be able to get consultations from their caregivers whenever she believes it is necessary.
- Along those lines, benefits such as gym membership subsidies are somewhat important to her and for her family s long-term health.
- While her family can afford the increase in premium and copayments, she is very concerned that health insurance is priced beyond many families affordability. It is becoming too expensive, in her opinion.

Respondent: 46-year-old woman

- Individual coverage; HMO Blue.
- She had no choice of insurance from her employer, but stated that her employer shops around and offers one plan, based on cost. She has been with the company for 12 years and switched health insurers a few times. She used to have Tufts and had to leave her PCP, which upset her because she sees him regularly as she has Lyme Disease.
- She feels she has a very good understanding of her benefits and services.
- She is a frequent user of her health insurance since she contracted Lyme disease when running. She used to see an oncologist and her PCP quite frequently, now she only sees her PCP once a year and her oncology visits are less frequent. She also takes prescriptions for Lyme disease ($35 copayment for every supply of pills). Due to her illness, she was no longer able to run and this led to depression, for which she was treated under her insurance.
- What she loves most about the plan is the $150 gym subsidy.
- There are lots of services she doesn t utilize, especially being a woman of her age. She wished that the plan would pay for chiropractic services.
- When asked what she would want to give up if times were tough she said she d be willing to pay higher copayments for office visits. Right now her employer pays about 80% of the cost of the insurance. She said she would not want her drug copayment increased because she utilizes it so much for her illness and that would be burdensome.
- She informed me that her employer uses an insurance broker for health insurance advice. When costs became too high he asked the broker to find him a new deal. He was offered a few different options which he shared with employees. He asked them to designate their preference and then he announced his choice. She said there is no discussion; you pick the one that best suits you, and hope a majority of other people pick the same one.

Respondent: 49-year-old woman

- Family coverage.
- This woman is insured through her ex-husband, but she pays her portion of the premium. The service area for this plan is Washington, D.C. where she used to live. Now that she lives in Massachusetts she travels to Washington for yearly checkups, but said that she has had to use an emergency room twice since moving. She paid 30% of those bills.
- She did not have a choice among health plan as it was part of the divorce decree.
- She said that she has a good understanding of her benefits through some literature that has been sent to her, but mostly through her own personal experience with the plan.
- She feels lucky, only utilizing health services for annual checkups or tests.
- The aspect she likes best about her health insurance is her freedom-of-choice.
- Her health insurance gives her access to services she does not use such as substance abuse treatment and mental health counseling.
- She said if her health coverage had to be changed in order to save money she would be willing to pay a higher copayment. She also said that she would not want to give anything up in order to achieve cost savings.
- She said the premium is quite high and sometimes she feels as though it costs her far more than she will ever use in services. She has health insurance in case of a catastrophe, but feels that those individuals who are healthy and use services infrequently should be rewarded in some fashion.

Respondent: 50-year-old woman

- Individual coverage; Health New England..
- She had a choice among health plans, but chose this one because it was cheapest.
- She feels she has a good understanding of her benefits.
- She generally uses health services for annual doctor visits and tests.
- The aspect of her health insurance coverage that she likes best is that she can remain with her PCP.
- She said there are things her health plan offers that she does not utilize, but even after probing she couldn t think of an example.
- If her employer needed to save money she would be willing to pay a little higher copayment. The thing she would least like to give up is coverage of annual doctor visits.
- She said her employer did not include employees in the decision-making process. They were given a choice of health plans and told to pick one.

Respondent: 50-year-old woman

- Family coverage; Harvard Pilgrim Health Care.
- This woman gets her health insurance through her husband s employer. He is a teacher.
- They had a choice among three health plans. The reason they chose this particular plan because it was cheapest.
- She feels as though they have a good understanding of their benefits. She gathered knowledge about the health plan through literature and a meeting her husband attended.
- They are lucky in that they don t use health services frequently. They make annual office visits and have some prescriptions. Her husband takes two prescriptions regularly, but for the most part they are healthy and have only had to visit a hospital three times in 20 years and they were not inpatient stays.
- The aspect of her insurance coverage she likes the best is that her copayments are low.
- Her health insurance gives her access to services they don t use. She cited dental as one service. Her health plan covers the dental care of her children up until they are 15 but they have a Delta Dental insurance plan so they didn t need it within their health insurance.
- If she had to give up something to achieve cost savings she would be willing to pay a little higher copayment. When asked what she would least like to give up she named the prescription drug benefit because her husband utilizes this service on a monthly basis for two different drugs.
- She said she was unsure if her husband s employer included him and the other employees in the decision-making process on choices for health insurance coverage.

Respondent: 54-year-old woman

- Individual coverage; BCBS Indemnity.
- Only one plan was offered by her employer. It did not require referrals or any kind of gate-keeping.
- She has a good understanding of her benefits and when she needs information she contacts member services.
- She uses health care services quite often about once a month. She has high blood pressure and receives gynecology services twice a year. She can see a physician any time she likes, as there are no restrictions on access.
- She does not think she is over-insured. She does not have more benefits than she needs.
- She likes best that she has complete freedom-of-choice in her plan.
- Her employer has increased the premium recently. But she prefers this to giving up benefits or freedom-of-choice.
- Employees are not included in decision-making about health care benefits.

Respondent: 55-year-old woman

- Individual coverage; BCBS.
- This woman is married, but her husband has a separate individual health insurance plan. They also have a third plan, as her husband is a retired police officer.
- She had a choice among health plans and her employer helped her to understand her options through literature and group sessions. She picked this plan because she liked it overall. She especially wanted and liked the fact that she would be able to remain with her primary care physician.
- She feels she has a very good understanding of her benefits and services.
- She said she seldom uses her insurance, only for checkups and prescriptions, but she said she has been lucky.
- The aspect she likes best about her health insurance coverage is her ability to stay with her PCP and her overall freedom-of-choice.
- When asked about whether there are services/benefits that she doesn t use, she couldn t name any, even after some probing.
- If her employer needed to save money, she said she would be willing to pay a higher premium or in some instances, higher copayments. When asked what she would least like to give up she said nothing she was adamant that she likes her coverage the way it is and didn t feel like she could do without any portion of it.
- When asked if her employer included employees in the decision-making she said she really didn t know. She works for a school department and said that there are so many different city departments, she doesn t know if or how they would go about doing it.

Respondent: 55-year-old man

- Family coverage; HMO Blue.
- This is the only plan offered by his employer. He's had it for three or four years; before that they had CIGNA.
- He feels he has a good understanding of its benefits and services, which he gathered through experience and some of their literature.
- He sees a physician once a year, as does his wife, and his wife has an regular prescription. They are generally very healthy people.
- What he likes best about the plan is its wide acceptance. Everyone recognizes the card.
- When asked about whether there are services/benefits he doesn't need, he immediately mentioned maternity. He wishes that it wasn't covered since they are past the age to need it. He said several of his friends have asked the owner to eliminate that and offer dental, but the owner said BCBS can't do that.
- When asked what he would want to give up if times were tough, he said he'd be willing to pay part of the premium. Right now the employer pays 100% of premium. So while his copayments have gone up, he still doesn t contribute to premium. When asked, he first said it would be impossible to estimate how much premium he'd be willing to pay, but he did say a friend contributes $70//week and that he'd be unwilling to do that unless he got a raise. When asked about $30/week, he said he would be willing to pay that in order to keep him coverage as is.
- He said that when the copayments went up this last time they heard about it in the mail to their homes. Even the boss said he heard about it this way.

Respondent: 58-year-old woman

- Family coverage; Fallon HMO.
- This woman works for the federal government. She was given a choice between Fallon and a BCBS plan that sounded like an indemnity plan.
- She obtained information about the plans through literature and could have attended a meeting where each one had representatives, but she was unwilling to wait on the line that that would have entailed.
- She picked Fallon because it offered the best value for the money in her opinion.
- While Fallon had a set copayment for drugs, BCBS required coinsurance. She wanted the certainty of knowing what her cost would be rather than the uncertainty of a coinsurance.
- Her premium for both plans would have been the same percentage of plan cost, but Fallon was a little cheaper so the percentage went farther.
- She doesn't think Fallon has things she doesn't need. Two years ago she took a BCBS plan that had a wide range of doctors, and offered freedom-of-choice.
- She switched to Fallon even though its network is thin where she lives.
- Even though Fallon still requires specialist referrals, which BCBS didn t, she felt Fallon offered more to her family. She said their greater number of restrictions was a tradeoff, something she could live with.
- She and her husband rarely go to the doctor.
- She has a good understanding of the services offered.
- If necessary, she would opt to pay more in premium for the same services and/or a deductible. She mentioned that the BCBS plan had a deductible.
- Her employer does not include employees in decision-making it's the federal government.

Respondent: 59-year-old man

- Family coverage; Fallon Health Plan.
- This man had a choice between Fallon and Central Mass Health Care. The latter was more expensive, and his doctor had recently left it to join Fallon, so it was an easy choice for him.
- In his work place, the percent of employer contribution to premium varies with one's hiring date: he has been employed quite a while at his present job, so he pays little toward premium.
- He said his employer taught him enough about the different plans to enable him to make a decision. Fallon covers what he needs and in fact recently added dental although he does not use it because his dentist is a friend and he won't leave him.
- His favorite thing about Fallon is that it is accepted everywhere in the Worcester area. The doctors are plentiful and all pharmacies take it. He has been hospitalized and he thought the coordination between hospital and health plan was smooth and the care good.
- When asked what he would vote for if prices had to rise or benefits shrink. he said that copayments have risen for drugs, office visits and emergency room visits lately. When pressed for an answer, a long conversation about health care costs ensued. He said he wouldn't mind the yearly price increases if he knew that the health plans, government, and providers were trying to do something at the same time to get at the root causes of the constant price increases. He would keep paying more if he had to because he knows the value of health insurance, but he doesn t understand where it's all going to end. He could afford to pay more in a health premium and is convinced he will keep paying more over time, but he doesn't think he has a good understanding of the cost structure. He has purchased an individual long-term care insurance policy since his mother had been in a nursing home paid by Medicaid and he felt that her care was terrible because of how little the government paid the nursing home.
- His company never consults employees about how best to distribute greater costs of health care, but it was his impression that his employer was dictated to by the health plan and didn't have choices.

Respondent: 60-year-old man

- Family coverage; BCBS Master Health Plus.
- His employer offered three BCBS products; this was the most expensive.
- He was given literature and there were speakers present to help him choose among the plans. He has had this one for a number of years.
- He chose this option because the benefits appealed to him. The other choices would have had higher copayments, but more importantly, restricted access to doctors. He would have saved a few bucks but it wasn't worth it to him.
- He and his wife have four children who in the past have used a lot of health services, including some hospitalizations and prescriptions.
- He feels they have a good understanding of the insurance product. The single most important thing to them is to go to whatever doctor they wish.
- He couldn't think of any benefit they're not likely to use or don't need.
- Three of his four children are now old enough to be insured on their own, so at the next enrollment he might try a more restrictive plan. The cost difference this year was $12/month to him and that wasn't worth it.
- His employer pays 80% of premium and is desperately trying to get them to drop this high option plan. His health benefits are negotiated by his union he is a teacher
- If pressed, he would pay more for copayments if necessary and possibly a deductible but never choose to limit his choice of doctors.
- His employer includes employees in decision-making since health care is a negotiated benefit.

Respondent: 61-year-old woman

- Family coverage; Fallon Health Plan.
- This woman who lives in Worcester is covered through her husband's insurance. He retired in November 2001, and his company is covering him through the age of 65. He doesn't contribute to the premiums and never has.
- They have been with Fallon for years. Although the employer offers other plans, Fallon has served them well and they stick to it. They have an adult Down's Syndrome child and although they had MassHealth for him at one point, Fallon guarantees him coverage for as long as the parents have Fallon (at age 19, he didn't have to leave his parents' coverage).
- She described her family as basically healthy. Their son sees his doctor once a year, her husband has sugar and she has high blood pressure. In the past year she has seen a doctor more frequently than in other years and she mentioned she may apply for disability. Her prescriptions cost about $50/month in copayments.
- She doesn t think her husband's employer includes employees in decision-making. They provide brochures about the plans they offer, sending the brochures home.
- She doesn t have any idea what she would prefer if her husband's employer had to save money on health care. She realized that she complained about prescription copayments when they pay nothing for insurance itself.

Endnotes

[i] Massachusetts Division of Health Care Finance and Policy, "Premium Increases Affect Health Insurance Coverage." *Analysis in Brief* (November, 2001, #3). www.state.ma.us/dhcfp

[ii] Massachusetts Division of Health Care Finance and Policy, "Health Insurance Survey of Massachusetts Employers, 2001."

[iii] White. Employers Anticipating Large Increase in Health Care Costs Next Year. *Los Angeles Times* (December 9, 2002)
Also Gabel, J., Levitt, L., Holve, E., Pickering, J., Whitmore, H., Dhont, K., Hawkins, S & Rowland, D. (2002). Job-based Health Benefits in 2002: Some Important Trends. *Health Affairs, 21(5),* 180-186.

[iv] See Galvin, R., & Milstein, A. (2002). Large Employers New Strategies in Health Care. *New England Journal of Medicine, 347(12),* 939-942.

[v] See Robinson, J.C. (2002, March 20). Renewed Emphasis on Consumer Cost-sharing in Health Insurance Benefit Design. *Health Insurance: Cost-sharing Web Exclusive*.

[vi] Schoenbaum, M., Spranca, M., Elliott, M., Bhattacharya, J., & Short, P.F. (2001). Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis. *Inquiry, 38(1),* 35-48.

[vii] See Strombom, B.A., Buchmueller, T.C., & Feldstein, P.J. (2002). Switching Costs, Price Sensitivity and Health Plan Choice. *Journal of Health Economics, 21(1),* 89-116.

[viii] See Wong, M.D., Andersen, R., Sherbourne, C.D., Hays, R.D., & Shapiro, M.F. (2001). Effects of Cost-sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study. *American Journal of Public Health, 91(11),* 1889-1894.

Percent Distributions of Selected Variables Across First Choice Options

	premium increase	MD copayment increase	limit of 2 teaching hospitals	none acceptable	drugs not covered but premium reduction	drug copayment increase	MD visits not covered but premium reduction
ALL	31.2	20.2	15.6	10.6	9.6	7.7	5.1
Gender							
Female	26.7	19.8	19.5	12.5	8.8	7.1	5.8
Male	34.8	20.5	12.6	9.1	10.3	8.3	4.6
Age							
18-39	26.9	18.7	19.6	9.4	12.4	8.9	4.1
> 39	34.8	21.4	12.2	11.5	7.3	6.8	5.9
Education							
< high school	22.1	7.8	23.7	18.8	8.6	0.0	19.1
High school grad & +	27.0	19.1	18.2	13.6	8.4	8.2	5.6
College grad & +	35.1	21.5	13.2	7.5	10.7	7.8	4.2
Income re Federal Poverty Level							
< 200% FPL	19.3	9.8	23.4	16.3	16.1	12.2	3.1
200-399% FPL	26.0	23.0	17.6	12.7	6.8	7.6	6.3
> 399% FPL	35.0	20.7	15.3	8.3	8.8	7.8	4.2
Health status							
Excellent/very good	31.4	20.6	13.0	10.5	11.7	7.9	5.0
Good	35.8	16.6	20.7	9.5	4.0	7.5	5.9
Fair	14.7	20.4	25.2	29.6	5.7	2.3	2.1
Poor	18.4	49.2	9.8	4.4	0.0	12.9	5.4
Uninsured family member							
Yes	23.7	15.6	20.0	14.7	11.7	10.9	3.4
No	31.9	21.2	15.6	10.3	8.6	7.3	5.1
Copayment							
< $11	32.2	20.1	16.5	10.9	7.9	7.8	4.5
$11-25	29.6	21.4	17.1	10.4	9.6	6.9	5.1
> $25	25.8	10.2	21.6	6.8	6.1	16.3	13.3

Figure 1: Individual Responses versus First Choices for Cost Sharing

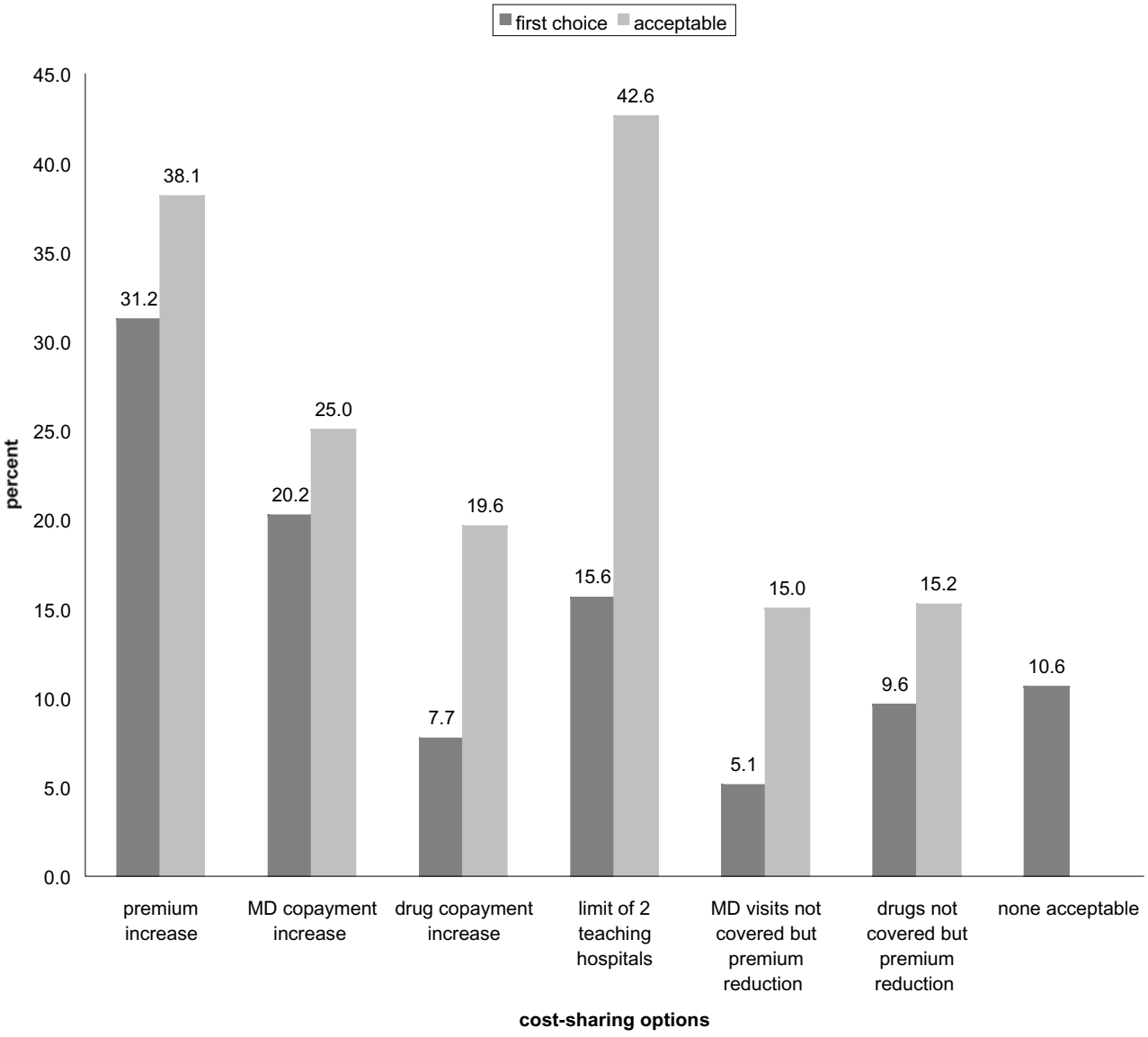

Figure 2: First Choices for Cost Sharing by Income and Education